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ABSTRACT

The author advocates an interdisciplinary team approach to diagnosis and prescription for the elementary school learning disabled (LD) child. Described is a 5-year project, funded under Title VI, operating within 11-18 elementary schools surrounding the University of Maryland Hospital. Biweekly services are offered to participating schools by a task-oriented multiprofessional team that includes a nurse, a physician, a diagnostic and prescriptive educator, a psychologist, a communications specialist, and a social worker, as well as the child's classroom teacher and principal. Stressed is the importance of monitoring the child's educational needs and re-evaluating his progress on a regular and frequent basis. Successful results of the interdisciplinary team approach are said to include observable educational improvement for 52 percent of LD children served during 1971 and improved inservice training (in such areas as early identification and development of specific prescriptive techniques) for regular class and resource room teachers. (LH)

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There are many potential causes for a child's inability to learn in the school environment. If one moves away from learning disorders as being specifically problems of perception and sensory processing and toward the concept that a child may not be learning for more general reasons, then the physician must consider a number of possibilities for impairments in learning. These potential causes may be viewed from an organic and a functional perspective. The specific child in question may have more than one definable reason for his inability to learn and may represent a combination of etiologic factors of both the organic and the functional variety. Thus, the physician is cautioned about "labelling" a child with specific entities thus excluding the possibility of secondary and tertiary causes as well as ignoring the dynamic nature of change in the developing child.

The categories to be mentioned are to be used as guidelines only - to provide a foundation for thought from which to further elucidate the specific problems of the individual child.

In the organic area, we may subdivide the possibilities so that the management implications become increasingly better defined.

1. Mental retardation alone: The current definition accepted by the American Association of Mental Deficiency is that mental retardation refers to subaverage functioning which originated during the developmental period and is associated with impairment in adaptive behavior.[1] Tests give no indication of greater intellectual potential and there is concomitant evidence of psychological retardation.

The management approach to this child must include the diagnostic input of the physician and psychologist, the counselling of social worker and child advocate, and the educational assessment and placement by the special educator.

Learning Disabilities: Diagnosis and Prescription

The premise of this paper is that the basis for the thorough diagnosis and successful educational prescriptive remediation for the learning disabled child is to be found in the process of interdisciplinary teaming. There is wide diversity of opinion among professionals involved in the field of childhood learning disabilities as to the accurate boundaries and definitions of the terms. Myklebust defines "psychoneurological learning disorders to include deficits in learning, at any age, which are caused by deviations in the central nervous system and which are not due to mental deficiency, sensory impairment or psychogenicity."[1] Kirk's definition goes somewhat further suggesting that a learning disability refers to a retardation, disorder, or delayed development in one or more of the processes of speech, language, reading, spelling, writing, or arithmetic resulting from a possible cerebral dysfunction and/or emotional or behavioral disturbance and not from mental retardation, sensory deprivation, or cultural or instructional factors.[2] The author of this article has added minimal brain dysfunction with hyperactivity or autistic qualities; primary emotional disorders; cultural deprivation; and emotional, educational, and developmental immaturity to the causative factors.[3] The true definition very likely lies somewhere within these varied interpretations of the term and the disorder. What becomes increasingly clear to the practitioner in the field of learning disorders is that the need for definitions becomes obsolete when a task-oriented, interdisciplinary, multiprofessional team assesses the individual child who suffers from an obstructed educational pathway.

The diagnosis of the etiological basis of the individual child's learning disability has created yet another major controversy among the professionals responsible for the development of remedial learning prescriptions. There is

a justifiable cry against the "labelling" of the specific child with an adynamic and unchanging singular diagnosis which he will carry as a "brand" upon his educational record for the remainder of his scholastic life. The labelling early in the child's educational career does not, in any way, take into consideration the dynamic nature of every child's intellectual growth and development during the evolutionary educational years. Without constant reassessment, the label given years before will become as obsolete and useless as will the same continued educational approach to the child.

However, a resolute and total disregard toward any attempt at making specific diagnoses relative to the individual child's strengths and weaknesses leaves the educator in the midst of a forest of educational symptoms without any map or compass to help the teacher guide the LD child toward the light of learning. It must be known where the child's problems lie and to what severity they are hampering his education before a rational and sane attempt can be made to program a remedial educational program for that particular child. Therefore, the diagnostic process must culminate in a definitive profile of the specific child's educational strengths and weaknesses.[4] These need not be permanent "labels", but those educational and behavioral qualities which are felt to be integral to the child's learning disorder. The ability of the task oriented interdisciplinary team to clearly define these specific strengths and weaknesses will overcome any controversy about "labelling" because each child will be evaluated as a separate entity, assessed by the many faceted professional views of the I/D team.

A major consideration in the diagnostic evaluation of the child with learning problems is the discovery by many investigators including the author of the article that the learning disabled child often has more than one significant etiologic cause for his educational handicap. In a recent study done by

the Behavior and Learning Team which the author directs at the University of Maryland Hospital, the findings of multiple etiologic bases for the problems of learning proved to be extremely meaningful. In children found to possess minimal brain dysfunction with hyperactivity as the primary basis for their inability to learn at the time of referral, 81% were also found to possess serious perceptual or processing problems which would seriously hamper learning once the random dysactivity was brought under control by appropriate drug therapy. In addition, 34% of these children were found to have communication disorders and 22% were found to have specific significant additional medical problems. Those youngsters possessing perceptual-processing problems as the major presenting educational weakness at the time of referral constituted 11.4% of the total sample (n=132). These children were noted in addition to suffer from emotional problems (21%); MBD with hyperactivity (21%); and communication problems (21%). Twenty-nine percent had evidence of some degree of minimal to moderate mental retardation by team analysis.[5] Thus there is an urgency to carefully dissect out the specific and definitive educational weaknesses as separate etiologic entities before a rational and accurate educational prescription can be written for the learning disabled child.

Thus the pressing need to circumvent the controversy over the varied definitions of LD; the requirement to focus on the individual child's strengths and weaknesses; and the complexity and multiplicity of diagnoses in LD children creates the appropriate background for the task oriented, multiprofessional, interdisciplinary team approach to learning disabilities. This is the basis of the Behavior and Learning Interdisciplinary Team directed by the author at the University of Maryland Hospital. This project has been funded for five years via Title VI federal funds through a grant from the Special Education Division, State of Maryland Department of Education.[6] This project will be totally

absorbed by the local school system after this final year of funding. Gradual absorption has been occurring during the past three years. The team consists of the following professionals who may be hired and funded through the local school system, special state and federal grant monies, the supporting hospital or the local health department (school health division): the school nurse; the school physician (who may be a specially trained physician in the area of behavior and learning or a regularly assigned school physician who is clinically alert to the latest advances in behavioral and educational Pediatrics); the diagnostic and prescriptive educator; the psychologist; the communications specialist; and the social worker. Each child's "team" contains the additional membership of his teacher, guidance counsellor and principal where available. Consultations with the child psychiatrist or neurologist are accessible though infrequently felt to be necessary by the group. The "team" is, by no means, a medical model; nor is it an educational, psychiatric or social work model. It is an interdisciplinary team model in which each member works assiduously to put together that part of the learning disorder puzzle presented by the individual child. The process is one in which the team functioning together writes a practical, thorough and meaningful educational prescription for each child.

The interdisciplinary team has worked on-site within 11-18 elementary schools in the school region surrounding the University of Maryland Hospital. The team has offered services to the selected schools on a bi-weekly basis. Complex cases are referred by the team to be seen once weekly in a specially organized "team" clinic within the Hospital's Pediatric ambulatory area. There they are fully reassessed and conferenced by all of the team's professionals plus consultant supervisors. Only about 10% of the children require work-up and conferencing within the special hospital clinic. The remaining 90% are

thoroughly investigated and conferenced by the team within the school environment where the educational prescription is discussed, written, and implemented on site.

The educational prescription may be singular or multi-faceted in the team approach to the child's problems. Any one member of the team or a combination of the team's professionals may become responsible for the implementation and monitoring of the specific team suggestions which emanate from the individual child conference. Re-evaluation and re-assessment of diagnosis and child progress is undertaken by the team on a regular basis (usually every three to six months) so that the dynamic alteration in the child's educational and emotional responses to his changing environment can be incorporated into the ongoing prescriptive process. Such teaming has resulted in positive responses from the educational system which it assists as well as positive results from the children whom it serves. During one year (1971), 52% of those LD children serviced by the interdisciplinary team already identified in this report demonstrated observable educational improvement.[7] During 1973, 91.4% of those children who received drug therapy for hyperactivity after careful assessment by the team demonstrated positive responses as measured by parent-teacher interviews.[5] Both the author's interdisciplinary team activity and the similar interdisciplinary school health team of Dr. Philip Nader in the Rochester, New York area[8] resulted in increased teacher referral, shortened referral-diagnosis time for each child, plus improved student performance. The best medication found for most of the youngsters seen by the University of Maryland Interdisciplinary Team has been "success". Children can move forward from success; continual failure has an unmistakeable paralyzing effect on the child.

Not all of the recommendations for educational and emotional remediation can be accomplished by the "team" itself. Much therapy must occur within the classroom. Here the diagnostic and prescriptive teacher and the communications specialist assist the classroom and resource room teacher in constructing and implementing practical and remedial programs for the individual child. Nurse-doctor-teacher conferences are designed to inform the teacher about the organic nature of the child's problem. Much in-service training has been accomplished while the team has functioned on-site within the schools. This teacher training has included earlier child identification, appropriate assessment of test measurements, specific prescriptive techniques, new methods of expanding communication skills, and appreciation of the positive and negative aspects of drugs for hyperactivity and behavior modification for learning deficiencies. Outside resources for the emotionally disturbed child, the physically handicapped child, the sensory impaired child and the severely perceptually disabled child must often be located and programmed for the more serious LD problem. Where these resources are not readily available, the on-site interdisciplinary team may serve as an active catalyst to assist the local school system in acquiring the necessary outside professional help.

The University of Maryland I/D Team has replaced the traditional school health-school physician model and the fragmented, periodic LEA supported professional services of social worker, speech therapist, and psychologist which has until this time functioned with inconsistent success in our national school scene. In the model described here, there is a union of all professionals - an interdigitation of available professional skills and languages to form an I/D team which works primarily on-site to remedy the outstanding elementary school health problem, the serious learning disorders of childhood. The interdisciplinary

task oriented team mechanism may be the first step toward a comprehensive successful approach to the yet unsolved dilemma of the handicapped child in our educational society.

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